

## SECTION 1: EXAMINATION FINDINGS

1. CANDIDATE'S NAME (LAST, FIRST, MI)				2. BIRTH DATE (MM/DD/YYYY)			
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3. SOCIAL SECURITY NUMBER Last 4 digits:		4. SEX <input type="checkbox"/> M <input type="checkbox"/> F		5. HEIGHT Without shoes:      FT      INCHES		6. WEIGHT Without shoes and coat:      LBS	
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7. VISION					8. BLOOD PRESSURE		9. HEARING TEST		10. RETEST			
UNCORRECTED		CORRECTED		<input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS	PERIPHERAL VISION:	Initial test BP after 3–5 min in chair: ____ / ____ Pulse: ____  Repeat if BP > 120/80: ____ / ____ Pulse: ____  Third test if 1 <sup>st</sup> & 2 <sup>nd</sup> reads differ by >5 mm Hg: ____ / ____ Pulse: ____		Left	Right		Left	Right
Far	Near	Far	Near									
Right				COLOR VISION:	Right		500			500		
				OTHER VISION TESTS:	Left		1000			1000		
Left							2000			2000		
							3000			3000		
Both						4000			4000			
						6000			6000			
						8000			8000			

11. For each of the following conditions, indicate **NORMAL**, **ABNORMAL** or **NOT EXAMINED** and include additional findings as needed.

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
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<b>A) SKIN</b>				
Color / Texture (lesions, scars, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tattoos (racist, gang-related, removal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>B) HEAD / EYES</b>				
Corneas (RK scars)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils / Light reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>C) EARS / NOSE / THROAT / MOUTH</b>				
Pinna / Canals / TM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal septum / Mucosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth / Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue / Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>D) NECK</b>				
Bruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C5-C7 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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**SECTION 1: EXAMINATION FINDINGS** *continued*

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
<b>E) ABDOMEN</b>				
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel sounds (Bruits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver / Kidney / Spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>F) CARDIOVASCULAR</b>				
Pulses: Radial, Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulses: D. Pedis, P. Tibial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apex impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart sounds (murmurs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart rate and rhythm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>G) CHEST / LUNGS</b>				
Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breasts (females age 50 and over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auxillary nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest wall expansion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>H) MUSCULOSKELETAL</b>				
UPPER EXTREMITY:				
Shoulder ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulder strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wrists / Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulder Apprehension Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grip strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BACK:				
Inspection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heel / Toe walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flexion / Extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Passive SLR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
L3-S1 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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**SECTION 1: EXAMINATION FINDINGS** *continued*

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
<b>H) MUSCULOSKELETAL</b> <i>(continued)</i>				
KNEES:				
Inspection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patellar apprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Duck-walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thigh circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lachman Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Collateral stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
One leg hop for distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anterior / Posterior drawer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>I) NERVOUS SYSTEM</b>				
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>J) GENITALIA / RECTAL – NOTE: Recent exam and test results from candidate's private physician are permissible.</b>				
Rectal <i>(age 50 and over)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inguinal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Male: Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Female: Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>K) LABORATORY FINDINGS</b>				
CBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chem. Panel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ECG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mammogram <i>(age 50 and over)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sigmoidoscopy <i>(age 50 and over)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PPD Mantoux <i>(if assigned to prisons)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CXR <i>(smokers age 40 and over)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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**NOTES:**

SIGNATURE OF LICENSED EXAMINING PHYSICIAN	PRINT PHYSICIAN'S NAME	DATE
		
ADDRESS OF PRACTICE (Street, City, State, Zip)		PHONE:
		(       )       -

### Instructions to the Physician:

- This section is to be completed and submitted to the hiring department.
- The hiring department will maintain the Medical Evaluation Report page in the individual's background investigation file. **Do not include medical information on this page.**

Candidate's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Last 4 digits of Social Security Number \_\_\_\_\_

On \_\_\_\_\_, I completed a pre-employment medical screening  
[DATE OF EVALUATION]

evaluation on the above-named peace officer candidate, in accordance with California Government

Code Section 1031(f), POST Commission Regulation 1002, and Commission Procedure C-2.

Based on the results and findings of that evaluation:

- ☐ **I certify** that the candidate is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department either without any accommodations, or provided that the specified work restrictions, limitations, or reasonable accommodations can be implemented. *(Describe any work restrictions, limitations, or reasonable accommodation requirements on the following page.)*
- ☐ **I cannot certify** that the candidate is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department.

Physician's Signature  \_\_\_\_\_

Printed Name and Contact Information:

[illegible]

### Instructions to the Physician:

**To the Hiring Department:**

Candidate's Name	Birth Date	Last 4 Digits of SSN
Examining Physician's Name ( <i>please print</i> )		Report Date